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# Applying Lessons Learned: Nursing Facility Administrators' Operational and Ethical Challenges During COVID-19

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## INTRODUCTION

As the incidence of COVID cases wanes with rising vaccination rates, nursing home administrators may, although hesitantly, breathe a sigh of relief that the worst is over. But is it? Scientists predict that "[f]uture pandemics will emerge more often, spread more rapidly, do more damage to the world economy and kill more people than COVID-19 unless there is a transformative change in the global approach to dealing with infectious diseases." (Daszak, et al., 2020, p. 10). While recommendations on environmental change are well beyond the scope of long-term care, the implications of the report are relevant for all health care providers, and especially for those serving over 1.2 million (Kaiser Family Foundation, 2012-2019) of the country's most fragile persons. Preparing for the next pandemic is critical, even as we are only easing out of the current one. A summary of insights from administrators across the U.S. describing their operational and ethical challenges during the pandemic provides an opportunity to learn from and apply lessons in order that facilities might be better prepared, owners might seek new models of care, construction, compensation, and quality assurance, and policy makers might offer improved guidance for future epidemics.

In the past 18 months, researchers have examined the potential explanatory relationships between nursing home COVID cases and deaths using a variety of variables including: quality ratings; nurse and aide staffing; presence of labor unions; type of ownership; place/location; racial make-up of residents; and community prevalence of COVID, among other topics (Ochieng, et al., 2021). Unsurprisingly, community prevalence of COVID has been found to directly relate to staff and resident cases in multiple studies as facilities and the community are entwined in numerous ways (Ochieng, et al., 2021; Doty, et al., 2020) This paper does not revisit such important research but drills down to the administrator level to understand more about the issues affecting day-to-day operations during COVID, especially those that relate to facility challenges in operations and ethical dilemmas created by the pandemic, and summarizes key issues and recommendations from administrators themselves.

Nursing homes are effectively "sitting ducks" where highly infectious diseases can spread rapidly, since most rooms house two residents and in some facilities as many as four. Restrooms are nearly always connected to another room, and bathing facilities are generally shared even more widely. Dining spaces are mainly congregate, and required living space, though different across the states, is generally less than 100 square feet per person. Compounding the issue is the everyday presence of visitors and rotating staff, many of whom work in more than one facility and at more than one job – (increasingly, agency workers are filling gaps during the pandemic) – providing additional opportunities to bring viruses and contagious infections into the facilities.

Making matters worse, some state health agencies and local hospitals used coercion to get facilities with empty beds to take infectious patients, despite the well-known nursing facility shortages of personal protective equipment, from 28.8% without a week's supply of PPE in June 2020 to 9.9% in March 2021 (AARP Public Policy Institute, 2021). Few nursing facilities have respiratory and other pulmonary services and equipment or appropriate isolation rooms. Lack of testing capacity in initial days followed by slow return of results did not help the issue, as visitors and asymptomatic workers infected others and, in many cases, their own families, worsening staff shortages. Hospitalizations for illnesses and trips to dialysis centers often meant further problems including risks inherent in transportation and possible environment-acquired infection. Blame-laying at the feet of nursing homes began early and has continued during much of the pandemic.

Although staff shortages and high staff turnover are not unusual in nursing facility positions, the pandemic created an even worse situation with many workers forced to stay home because of school closures or illness within families. According to the American Association of Retired Persons (AARP), as of March 21, 2021, 22.4% of facilities were continuing to experience staffing shortages of nurses and aides in March 2021. High turnover has long been linked to poorer quality in nursing facilities, findings on which some researchers have elaborated by examining staff turnover and infection control citations. In a draft paper, Loomer, et al. (2020, p. 3) found that "RN, LPN, and CNA turnover are all positively associated with the probability of an infection control citation. Staff turnover should be considered an important factor related to the spread of infections within nursing homes."

Infection control has long been acknowledged as a challenge for many nursing homes, in part because of high nursing/patient ratios compared to hospitals, lack of focus and education on infection control, and inability to control resident behavior. The U.S. Government Accountability office, citing concerns of management of COVID with poor infection control, reports: "About half—6,427 of 13,299 (48 percent)—of the nursing homes with an infection prevention and control deficiency had this deficiency cited in multiple consecutive years from 2013 through 2017. This is an indicator of persistent problems at these nursing homes" (U.S. Government Accountability Office, 2020, p. 4).

Expectations that facilities could simply cordon off a section of buildings as a COVID-19 unit were unrealistic in most facilities, because of age of the facilities, building layouts, and the inability to find and hire staff for higher acuity levels. Nursing homes are more like ships than sailboats, that is, they generally turn slowly because of the many regulations, low staffing levels, tall chains of command, and the institutional nature of most homes that are part of multi-facility chains or hospital systems. Shifting from the long-heard mantra of offering a "home-like environment" to a more hospital-like environment went against the grain for many employees, residents, and families and reflects a mismatch between current accepted staffing schemes in which nursing assistants deliver the bulk of care and the different needs of acutely ill patients.

Staff turnover during COVID may well have had an effect on the number of cases. Using Medicare data, the Center for Infectious Disease Research reported that of facilities included in the study, almost 79% had COVID cases and 43.5% had COVID deaths, the rates higher in facilities with larger numbers of non-white patients (Van Beusekom, 2021). Loss of life, although dropping to 0.2 per hundred in March from 1.95 per hundred in January 2021 (AARP Public Policy Institute, 2021), has taken an emotional toll on staff, residents, administrators and families.

Perhaps worst of all was the widely reported and photographed separation of residents from their families and friends, even as they were dying. Despair, depression, and rapid decline resulted from this well-intentioned isolation, a miasma that spread throughout buildings to residents and staff with little access to psychological support or counseling. Exceptionally long work hours for staff did not help, but such demands were essential to keep buildings staffed.

COVID-19 has given rise to pressing ethical dilemmas that nursing facilities do not always feel equipped to handle or do not identify as ethical issues, since some are daily issues unrelated to the end-of-life and conflict issues that many people associate with ethics. These include "autonomy-related problems, informed consent, use of restraints, offensive behavior, or refusing medication, food and bathing" (Bollig, 2016, p. 2) that many staff members may feel unequipped to handle appropriately. While most urban and suburban hospitals have access to an ethics consultant, few long-term care facilities have any designated person to guide facility leaders and staff, medical personnel, and families through such discussions to ascertain what is sometimes described as the "least-worst solution." Some facilities have no ethics policies or committees, other than organizational policies that might not help guide any day-to-day decisions that affect daily ethical challenges during the pandemic. Others depend on the owner or corporate decision-makers, who might not have knowledge of ethics or familiarity with individuals and families, or specifics in dilemmas local staff are facing.

Some researchers contend that part of ethical treatment of others should include the use of ethical values well beyond beneficence, autonomy, and justice that go further to realize "moral obligations to include support for maintaining . . . essential parts of the self." (Holstein, 2015, p. 375). This refers to the necessity of valuing each resident's own story and interests, something that might be overlooked in training of nursing assistants because the primary skill set is considered basic care. The constant churn of employees compounds the issue as there are fewer opportunities for residents and staff to bond. When demands are extremely high for caregiving as they have been during the pandemic, the opportunity for caregivers to show interest in one's personal narrative is near impossible. Lack of family support and shortages of staff and time to devote to residents, at a time when administrators had difficulties in attracting new employees, became an ethical problem, though it might not have been identified as such. Also relevant is the possibility that individual needs are subsumed by public health needs, creating ethical conflicts. "To shift between an individual patient focus and a comprehensive community focus challenges traditional ethical and moral concepts of beneficence, autonomy, advocacy, and social justice" (Pope, et al., 2016, p. 3).

***Methods***

An anonymous survey composed of 12 questions, 11 of them multiple choice, was sent to administrators through outreach to professional long-term care, licensing board, and administrator organizations and their social media sites throughout the U.S. with requests to share the link among the membership to foster higher participation. Data was analyzed based on demographics identified in the survey include an urban-rural scale, size of facility, identification as a COVID hot spot, and type of facility ownership. Questions sought information about major challenges related to staff and residents and whether ethics policies and resources played a role in decision making. Administrators were also provided an opportunity to respond to an open-ended question on operational and policy changes that they would recommend to improve outcomes in the event of a future outbreak of infectious disease. The primary focus of the survey was viewing administrators' operational challenges through an ethical lens.

***Results***

A maximum of 349 administrators or related parties completed the survey, although the number of respondents differed depending on the question. Questions that allowed for multiple answers resulted in higher numbers of responses. The chart below provides a description of facility demographics collected, including profit status and organizational type of the respondent facility. Some respondents listed only the profit status *or* the ownership status, but not both, which likely skewed ownership and tax status. Location and facility bed count are also included.

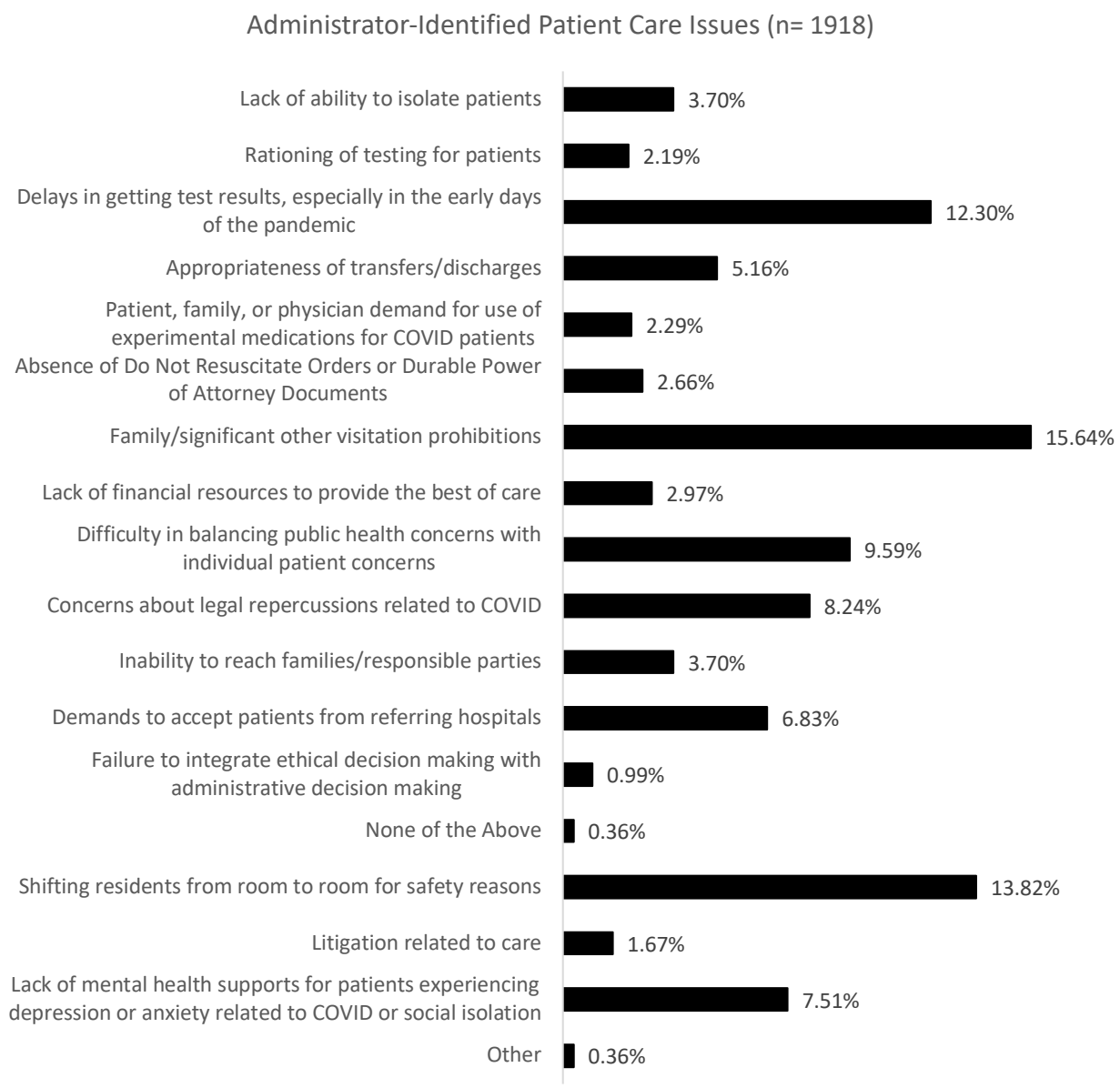
*Demographics*

| Profit Status of Surveyed Facilities | | | Actual U.S. (Harris-Kojetin, et al., 2019, p. 8). |
|---|---|---|---|
| For Profit or Non-profit | Number | Proportion | |
| For profit | 184 | 68% | 69.3% |
| | | | |
| Non-profit | 86 | 32% | 23.5% |
| Government and Other (Included in ownership below) | | | 7.2% |
| Types of Ownership/Operations of Surveyed Facilities | | | |
| Independently owned (May include small chains) | 100 | 58% | |

| | | | |
|---|---|---|---|
| Member of a non-hospital chain | 25 | 14% | Chain affiliated: 57.6% (Harris-Kojetin, et al., 2019, p. 9). |
| Owned by a hospital or hospital authority | 18 | 10% | |
| Government-operated, for example, VA | 21 | 12% | |
| Other: religious organizations, employee-owned | 9 | 5% | |
| Location of Surveyed Facilities | | | |
| Urban | 96 | 27.7% | |
| Suburban | 79 | 22.8% | |
| Rural | 172 | 49.6% | |
| Number Beds in Facility – U.S. Average 109/Facility (Harris-Kojetin, 2019, p. 10) | | | |
| 25 or fewer | 5 | 1% | 5.7% |
| 26-50 | 42 | 12% | 63.6% |
| 51-75 | 66 | 19% | |
| 76-100 | 80 | 23% | |
| 100-200 | 132 | 38% | 30.6% |
| 200 or more | 23 | 7% | |

***Day-to-Day Issues***

Various aspects of care and staffing, described in the chart that follows, were typical of day-to-day COVID-related concerns identified in the survey. PPE was often consumed by larger and acute healthcare entities and shortages led to price inflation, if materials were available at all to nursing facilities in the early days of the pandemic. Few nursing homes have ventilators or other specialty equipment or specialty staff, limiting their ability to serve their own patients or accept very ill patients from hospitals, yet demands were often made from health systems and long-term referral resources. Testing in-house at a hospital can be prioritized, an issue not as easily resolved in nursing homes without certified labs or ready access to testing equipment. Patient care issues described by administrators included the following (see graph below):

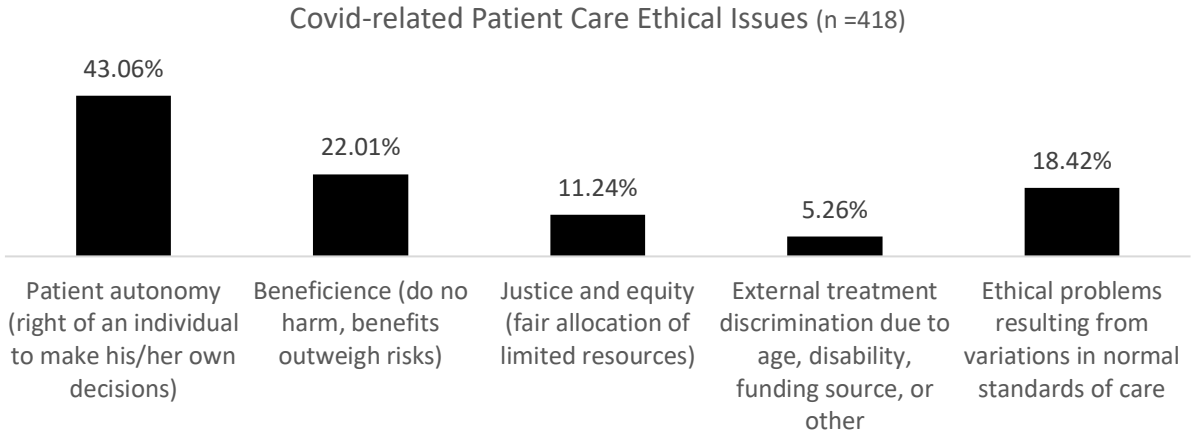



Other patient care issues identified in an open-ended question included the following: staffing (addressed separately), "need to use life-saving drugs"; "politics and media hostility with saving the residents"; isolation causing decline in residents; significant conflicts between CMS, CDC, OSHA, and state operations manual [compounded by] difficulty in navigating the web sites despite efforts to stay on top of requirements; citations during challenges with PPE and delays in testing; and an overreaching health department.

Many of these issues are reflected in administrator responses to questions about the ethical issues that arose during the pandemic as related to patient care. Note that patient care issues

demonstrate administrator awareness of real-world issues as viewed through an ethical lens. Yet, despite this awareness of ethical principles, most facilities represented in the survey did not have an

ethics committee or feel the need to call an ethics committee even during the darkest days of the pandemic. Of 349 respondents, 239 (68.5%) reported not having a functioning ethics committee. Clearly,




patient autonomy was a major stressor in nursing facilities, as residents had to be kept from socializing and were not allowed to see friends and family, a prohibition that has now been loosened. Those facilities with an ethics committee reported a greater need to use a committee for decision-making than those without. Of facilities without an ethics committee, 10.5% said that they needed to hold a committee meeting. Of facilities with functioning ethics committees, almost 38% said that they needed to hold a meeting to discuss COVID issues. This could imply that having a committee and education on decision-making tools available through the ethics deliberation process can provide helpful tools to assist stakeholders as decisions are made. However, almost 90% of those without a committee, compared to 62.4% of those with a committee said that they did not need an ethics committee meeting during the pandemic. There appears to be a disconnect between the vital role an ethics committee can play and day-to-day issues, despite awareness of administrators about ethical concerns. Some administrators explained that they turned to owners or corporate staff for help, but few described an internally driven process for discussion of difficult patient-related concerns that extend beyond end-of-life issues. The contingency table below describes the relationship between those facilities with and without committees and responses on the need to hold an ethics meeting during the pandemic

The Fisher exact test statistic value is < 0.00001. The result is significant at $p < .05$.

| | No Ethics Committee | Yes - Functioning Ethics Committee | *Marginal Row Totals* |
|---|---|---|---|
| No Need for Ethics Committee Meeting | 214 | 68 | 282 |
| Need for Ethics Committee Meeting | 25 | 41 | 66 |
| *Marginal Column Totals* | 239 | 109 | 348 (Grand Total) |

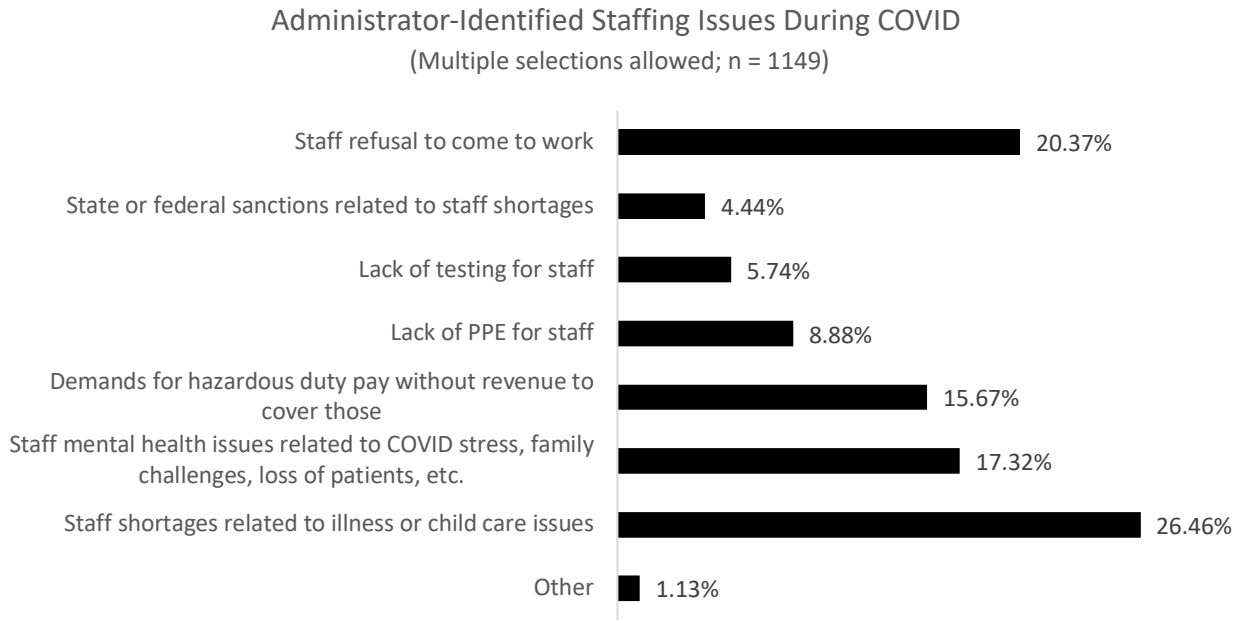
When asked about facilities' primary resource for guiding ethical decision making, administrators responded as follows:


Other, not included in the options above, included the following: governing boards/corporate staff/owners; quality assurance/improvement committee; quality organizations; CDC; CMS; corporate compliance director; ethical and religious directives for Catholic Healthcare/religious affiliation; used policies but need a "true" ethics committee; interdisciplinary team with input from resources noted [in survey]; policies and the need to adhere to the standard of care; simply doing the right thing; lots of different resources; and our culture of best interest of residents/our residents/resident-centered decision making.

In response to a question about whether ethics policies have provided effective guidance, almost 58% said yes, 16% said no, and nearly 22% said that they did not have any ethics policies. Only 4% said that they had experienced no COVID cases and no effect from COVID. There was no significant relationship between urban, suburban, and rural facilities and the presence of ethics policies.

### *Staffing*

Staffing was identified as a tremendous problem among most respondents. Lack of qualified staff to manage higher acuity and employee job-shifting for higher pay affected many administrators, but primary challenges for administrators were employee refusal to come to work and staffing shortages caused by employee illness and lack of childcare. Staff demand for hazardous duty pay expedited departures. There were no significant differences in staff issues based on rural, suburban, or urban status. Administrator-described issues with staffing appear in the chart below.




Other included a wide variety of answers: stimulus money/unemployment payments disincentivizing work; staff burnout; resignations due to refusal or failure to follow PPE requirements; refusal to work in the COVID unit; early shortages of PPE; no bonus from CARES Act/no reward for hard work; lack of qualified applicants/few applicants to fill positions; compassion fatigue; chaos due to pace of change; and multiple departments/agencies giving differing directions. Concerns about staffing were widespread and primary, especially when refusal to come to work and inability to come to work due to illness or child care issues are considered. Those two categories alone amounted to almost 47% of responses, painfully magnified by the fact that 4.4% of respondent facilities said that they been sanctioned related to staffing. Lack of PPE and testing were together responsible for 14.55% of staffing issues. Other drivers of shortages were mental health related to demands and losses and demands for hazardous duty pay, which drove some employees to job hop for more money.

Perhaps the most important findings of the survey are those open-ended remarks that describe the experiences and recommendations of administrators during the pandemic.

| Category | Administrator-Proposed Changes, Recommendations, Challenges |
|---|---|
| Directives, changing regulations, mixed messaging from authorities | ● Too many directives from too many agencies, sometimes conflicting; changes daily; need a clear and complete plan and consistent guidance agreed upon by all parties that keeps residents safe<br>● 50 states: 50 different policies<br>● Everything dictated - allow facilities to make some of the decisions that would best serve their residents depending on the needs |
| Sanctions, threats that "there will be enforcement actions" | ● Sanctions and threats compounded difficult situations<br>● Enforcement actions are not appropriate in this type of situation that was new to all of us; we are all still learning<br>● Sanctions from surveyor observation from outside a window |

| | |
|---|---|
| Ethics, residents' rights | ● Need ethics as a focus<br>● Consider that residents' needs vary<br>● Directives put policies before our residents; residents' wishes previously trumped everything - pandemic made their voices silent |
| Staffing issues | ● Keep staffing at an acceptable range; need mandated staffing; higher staff to resident ratios; need for more skilled nursing to reflect higher acuity of today's patients<br>● Create a larger pool of external staff<br>● Ensure adequate compensation for front line staff; mandated pay levels that are comparable to competitors (e.g., hospitals)<br>● Create a culture of respect for aides and the work they do<br>● Ensure leadership to avoid complacency<br>● Figure out how to get caring staff who want to care for nursing home residents |
| Building redesign; infrastructure | ● Creation of "neighborhoods" that function independently for greater ease of isolation<br>● Eliminate shared bathrooms, increase private rooms<br>● Continue down the path of privacy first with consideration for community as an integral part of design<br>● Physical layout and design of communities to ensure quality of life and promote infection control |
| Enhanced planning process | ● Improve planning processes<br>● Ensure better contingency staffing planning<br>● Better planning for situations when schools and daycares close |
| Better collaboration and less pressure from hospitals | ● Pressure from hospitals to take COVID patients despite our lack of equipment, PPE, ability to isolate, lack of sufficient skilled staff<br>● Hospitals need to realize that nursing facilities don't have the financial depth they have<br>● Blame goes to SNFs when it is often not warranted<br>● More collaboration with hospitals |
| Improved infection control and requirements for vaccines for staff, residents, and families | ● Everyone wears N95 masks all the time<br>● Everyone fitted for masks to ensure proper protection and then facilities order masks<br>● Restrict visitation to front of facility during epidemics<br>● Purchase air purifiers for all resident rooms and common spaces |
| More state and federal support | ● State provides emergency response teams promptly<br>● Government agencies need to be more prepared and supportive of the long-term care industry |
| Reimbursement that recognizes true cost of proper care | ● Reimbursement in line with care<br>● Health care systems and funding need to be integrated in order to provide proper care |
| Mental health supports | ● A national pool of mental health providers to be available in times of crisis for residents and staff |
| Policy changes | ● Public policy needs to consider the needs of all Americans, including those in nursing facilities<br>● Need to consider how to get all Americans vaccinated, including families of residents<br>● Policies against price-gouging for supplies and equipment |

| | |
|---|---|
| | ● Government aid directed to nursing homes<br>● Make testing more affordable or subsidized<br>● Implement federal requirements to get vaccinated |

## CONCLUSIONS AND RECOMMENDATIONS

Personal stories shared by administrators reflect their herculean efforts to provide proper care to their residents, made difficult in part because they could see the functional decline of residents while feeling the barrage of attacks from media, regulatory organizations, and threats of lawsuits. Scrambling for PPE and for adequate staff, these administrators found that their efforts did not always result in successful outcomes because there were just no solutions in areas where COVID was rampant and resources and staff were unavailable. Administrator comments present a great sense of fatigue with the never-ending losses of patients, complaints from disgruntled families, and attempts to replace staff, and despite best-effort-failures, compassion fatigue was only mentioned by one respondent.

Respondents made clear that they never lost sight of resident rights or standards of care, but there appears to be a disconnect between understanding the issues and taking advantage of ethical decision-making processes or relying on ethics policies. Over 81% of facilities did not see a need for an ethics committee meeting, and nearly 22% had no ethics policies. Facilities were often dependent on outside resources, including corporate staff or owners, for decision making. It is certainly likely that facilities, especially independent and small chain facilities that predominate in this survey, are not routinely exposed to ethics training or do not have the staff to implement the processes necessary, despite the long-term benefit that could accrue to the facility, staff, residents, and families. Compliance officers, which are an essential part of mandated compliance programs, could serve as train-the-trainer leaders to facilitate ethics committees. Key is the development of in-house deliberation to help facilities in both future crises and everyday decision-making beyond end-of-life issues.

Some administrators clearly felt their facility's inability to immediately muster troops or supplies for the pandemic, which resulted in unwarranted threats and expensive sanctions at a time when occupancy rates were at historic lows, leaving facilities with reduced income for operations. According to an article in *Provider Magazine*, occupancy rates at nursing facilities dropped on average by 13.3% from February until December 2020 to a low of 71.7% (Connole, 2021). Many of the facilities in this survey are rural, where declining population may mean more empty beds that are difficult to fill. The future of some organizations may be in doubt, and the entire industry is subject to bad public relations, loss of income, and the malaise that has settled over some facilities with loss of residents and staff.

Concerns about staffing, including sufficient staff and nursing staff, were widespread and primary factors in administrators' worries in assuring that the residents had proper care. The need for mental health resources was often unmet and such resources could have been beneficial for both staff (a major driver in turnover) and residents. Low Medicaid reimbursement in some states has been a factor in minimizing resources, although some critics believe that the preponderance of for-profit facilities and hedge-fund owned operations have had a role in reducing the level of care available. The news that "Deaths tied to long-term care facilities account for 35 percent of America's COVID-19 fatalities, even though less than one percent of America's population lives in such facilities" (Paulin, 2021) led to widespread negative responses about nursing facilities' ability to care for their patients. This explains, in part, why some administrators felt that they were unfairly blamed or sanctioned for losses, given the revolving door of staff and the fact that existing staffing requirements were not adequate for so many very ill, fragile residents.

There are hopes for the future: "The COVID-19 disaster presents an opportunity to reimagine the role of nursing homes. To begin with, the physical design and operating model of these nursing homes must be revised to accommodate the need for patient isolation [and] social distancing . . . ," (Fulmer, et al., 2020,

p. 2) while considering the social and emotional needs of residents. Realization of the true cost of providing services is essential and must be reflected in how facilities get paid. Creating a culture of healthcare, not only basic care, has long been a missing element in many facilities, despite the fact that more and more residents are there for short-term care that, until recently, would have been provided at hospitals.

Most Americans are ill-prepared for long-term care that over half (Hurd, et al., 2017, p. 4) may well need in the future. Assuring that post-acute alternatives are available and ready to serve is essential. Nursing home leaders must consider formally making recommendations that will ensure that they can meet changing needs in the society, including higher acuity patients and more extended pandemics, while supporting traditional long-term care. These recommendations should include the following:

- Define and promote new prototypes of care and promote adoption of existing models of small community approaches to care;
- Examine differences in outcomes between for-profit and nonprofit facilities to determine if residents are better served in one type of environment over the other;
- Add skilled nursing staff and enhance training for front-line caregivers;
- Implement a campaign to promote the value provided by nursing home aides and other front-line workers;
- Mandate staffing levels and require daily monitoring as an internal compliance issue, not just a regulatory requirement;
- Encourage nursing facilities to broaden their service lines to include home care, adult day health, and, where needed, support for home dialysis, to ensure that patient needs are being met in the right place at the right time with the right staff, while assuring the least restrictive environment and greatest patient autonomy;
- Examine states with long-term care Certificate of Need laws to determine if these laws are limiting new construction and competition to the detriment of residents whose only choices are aging facilities with insufficient building infrastructure and limiting more creative options for improved care;
- Increase financial support for mental health services in nursing facilities, including telemedicine, which has been underutilized;
- Provide allowances for new construction or renovation that will accommodate changing needs like the pandemic;
- Explore new forms of reimbursement based on what would better meet patient/resident needs and ensure value for money spent, (e.g., aide follows nurse home upon discharge when needed);
- Use state organizations and provider groups to provide training on ethical issues and processes for conducting ethical decision making; require all employees to complete ethics training as part of their compliance programs;
- Redesign/rethink the survey/sanction process to achieve quality improvement and good outcomes instead of the adversarial type of relationships that currently exist in most states that do not always achieve the intended goals;
- Ensure that contradictory directives are not sent by agencies to whom the facilities look for guidance by naming one lead agency for final regulatory advice;
- Support efforts to provide affordable childcare for children of employees, when the need is warranted and numbers are sufficient;
- Manage government stockpiles to ensure sufficient PPE is made available to nursing facilities when emergencies arise;
- Train National Guard troops, first responders, firefighters and other groups and professionals to assist in times of national emergency as during COVID-19; and

- Require facilities to update emergency plans and include identification of resources previously not considered but, using lessons learned, required during widespread epidemics.

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